PODIATRIC RECORD

This complete record is confidential

Medical Alerts	Patient's Name				Today's Date
	Case No.	X-Ray No.	Age		Birthdate
	Residence Address		City	State	Zip
	Home Phone	Social Security No.	Driver's License No.		
	Spouse's Name/Parent or Guardian's Name if a Minor				

Employed By	Occupation	Business Phone

Whom may we thank for referring you?	Address

Name, address and phone of contact in case of emergency

If other than patient, name and address of person responsible for this account

Do you have Medical Ins? ☐ Yes ☐ No	Carrier Name	Subscriber Name	Policy No.	Group No.

Is it through your employer? ☐ Yes ☐ No	Is there secondary ins.? (Spouse, Medicare, etc.) ☐ Yes ☐ No	Carrier Name	Subscriber Name	Policy No.

Name of former podiatrist	Name of family physician	Phone No.

Are you currently under your physician's care? ☐ Yes ☐ No	If yes, for what?	May we contact your physician for your health records? ☐ Yes ☐ No

If any, what kind of podiatric treatment did you have?	When did you have this treatment?

Major foot complaint is:

This condition(s) has existed for: ______ Days ______ Weeks ______ Months ______ Years	What medicines do you take regularly?

List any medical conditions you have (allergies, impairments, etc.)

	Yes	No	Comments
Is your general health good?	☐	☐	______
Have you have any serious illnesses or operations?	☐	☐	______
Have you had any injuries or operations on your feet or legs?	☐	☐	______
Do you have bleeding tendencies?	☐	☐	______
Do you have or have you ever had leg cramps?	☐	☐	______
Have you or any family members been treated for diabetes?	☐	☐	______

Check (✓) any of the following that there has been treatment for:

☐ Heart problems ☐ Asthma ☐ Epilepsy ☐ Rheumatic fever ☐ Kidney problems ☐ Liver problems

☐ Arthritis ☐ Bursitis ☐ High blood pressure ☐ Low blood pressure ☐ Other—what? ______

Check any existing allergies ☐ Novocaine ☐ Penicillin ☐ Adhesive tape ☐ Fabric ☐ Other—what? ______

Height ______ Weight ______ Temperature ______ Pulse ______ Blood pressure ______

I hereby give Dr. ______ permission to examine and treat my feet.

Patient's Signature ______

If a minor, parent or guardian's signature ______

Relationship to minor ______

Summary (doctor use)